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(54) **THORACIC ACCESS PORT INCLUDING
FOLDABLE ANCHOR**

(75) Inventors: **David Gregory Ahern**, Welney (GB);
Robin Craig Cocker, Oldham (GB)

(73) Assignee: **Covidien LP**, Mansfield, MA (US)

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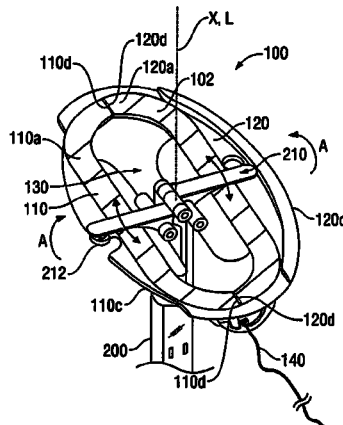
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(57) **ABSTRACT**

A surgical access device includes a body having a first member and a second member relatively movable between open and closed configurations. Each member is positionable within an opening in tissue to provide access to an interior space of a patient. Each member includes a top surface, a bottom surface, a leading end, and a trailing end. The top surfaces are positioned in close cooperative alignment when the first and second members are in the closed configuration. The trailing ends are positioned in close cooperative alignment when the first and second members are in the open configuration. In the open position, the first and second members define a passage therethrough to permit access to the interior space for passage of a surgical instrument there-through.

8 Claims, 9 Drawing Sheets



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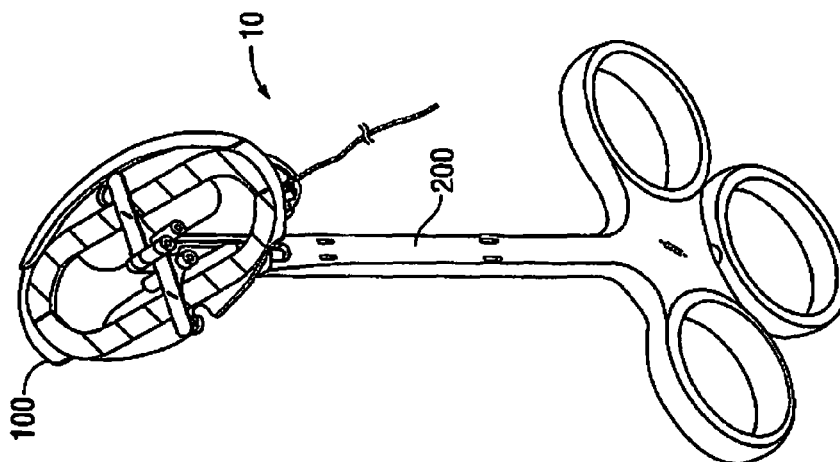


FIG. 2

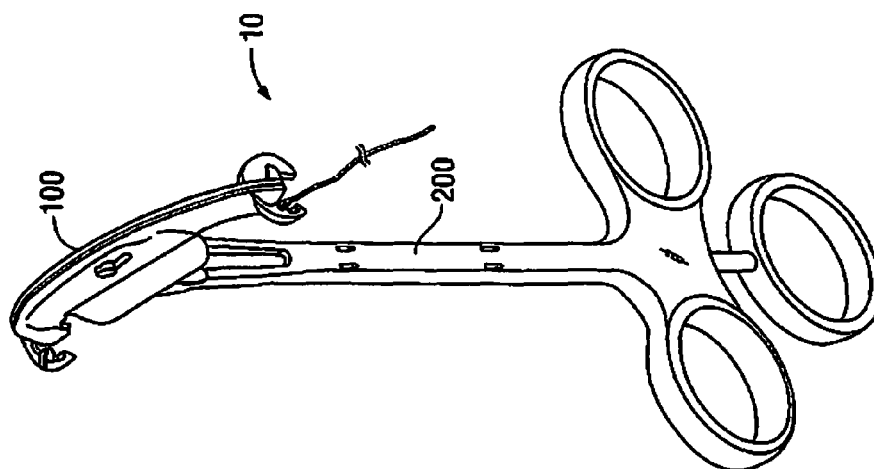


FIG. 1

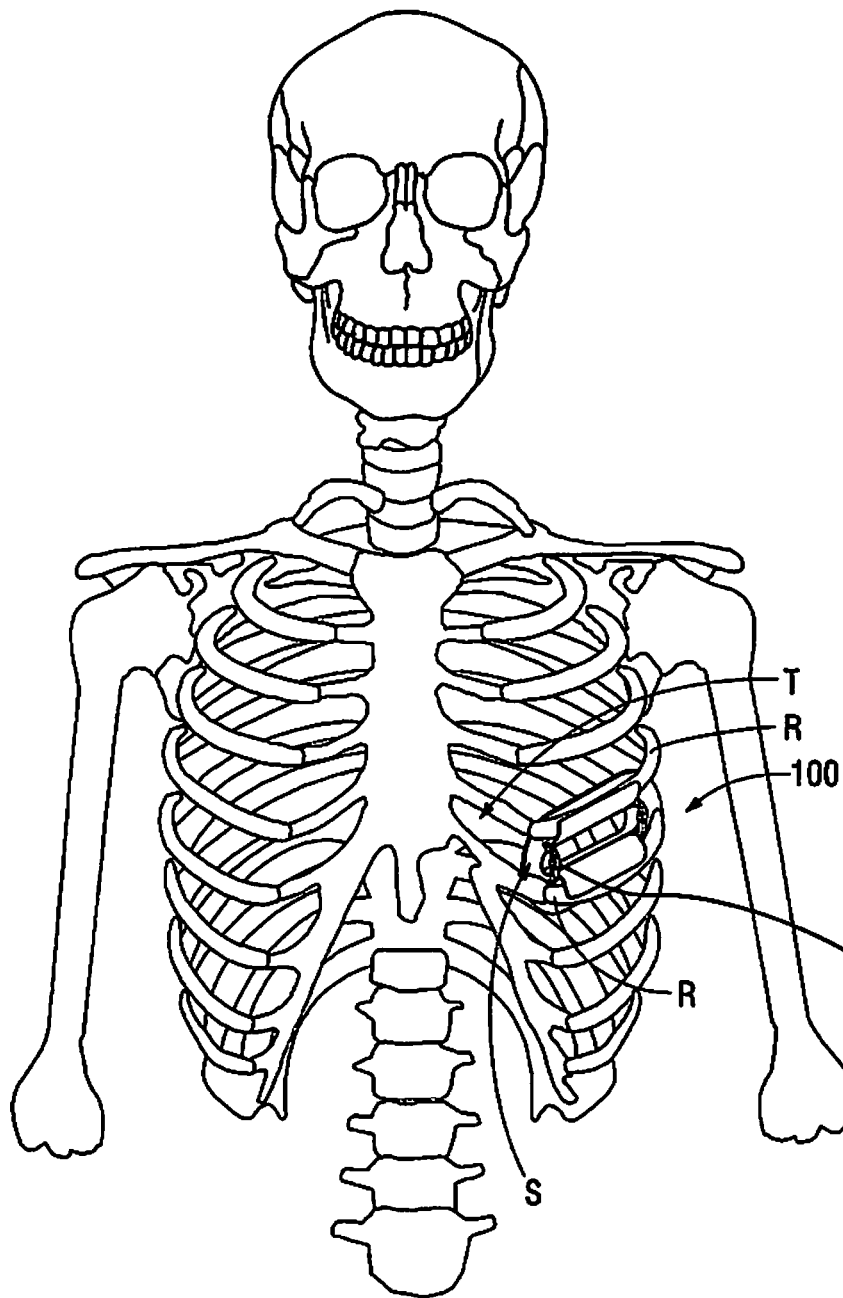


FIG. 3

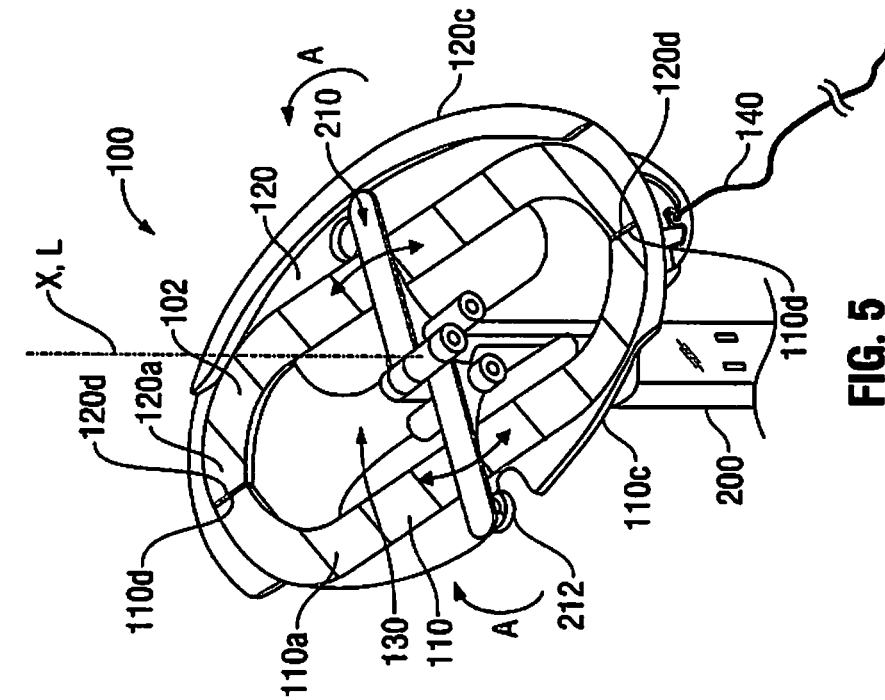


FIG. 5

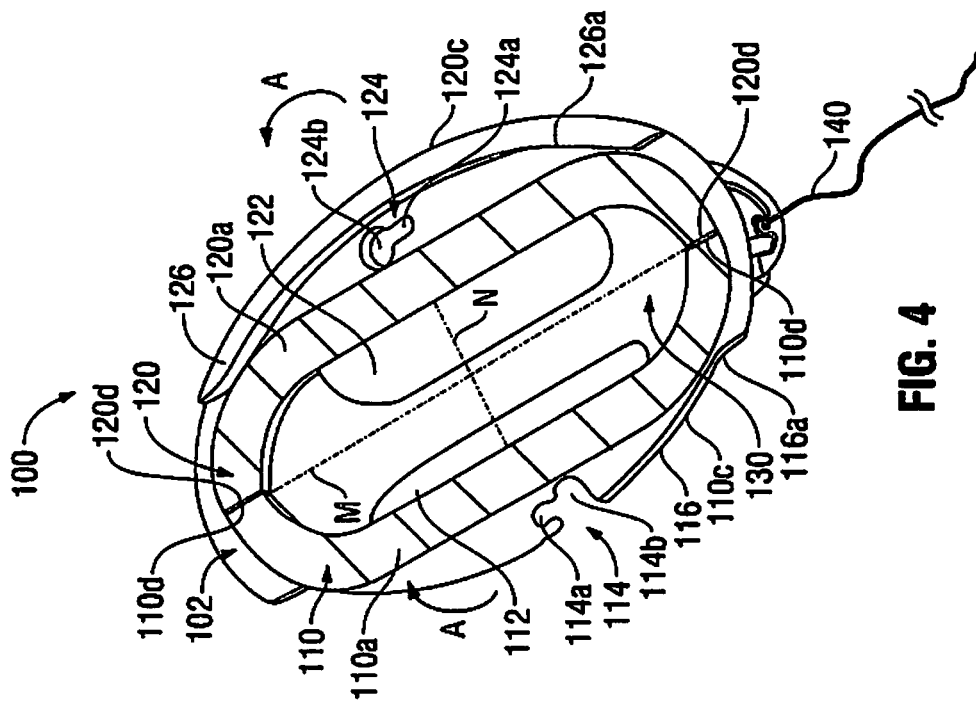


FIG. 4

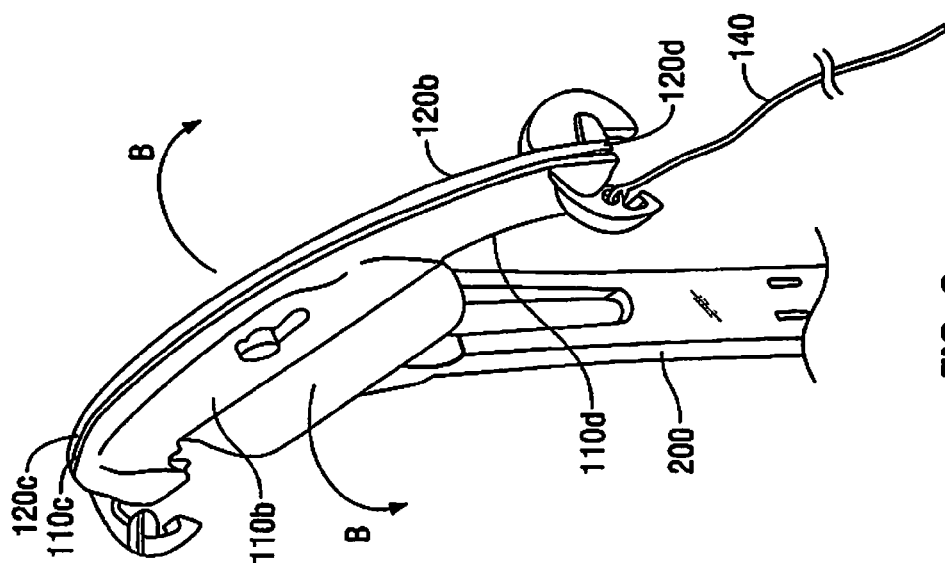


FIG. 6

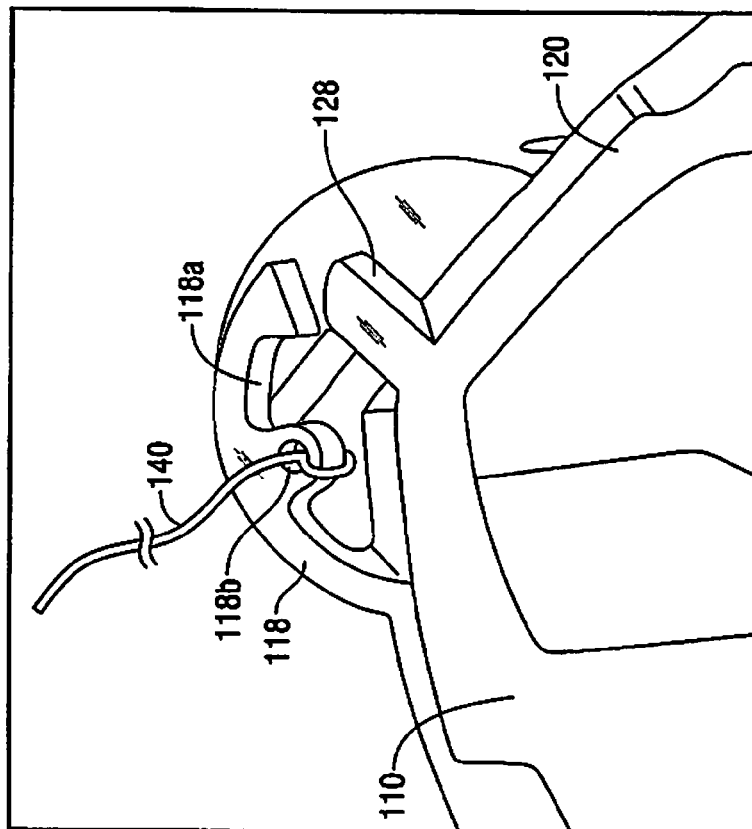


FIG. 7

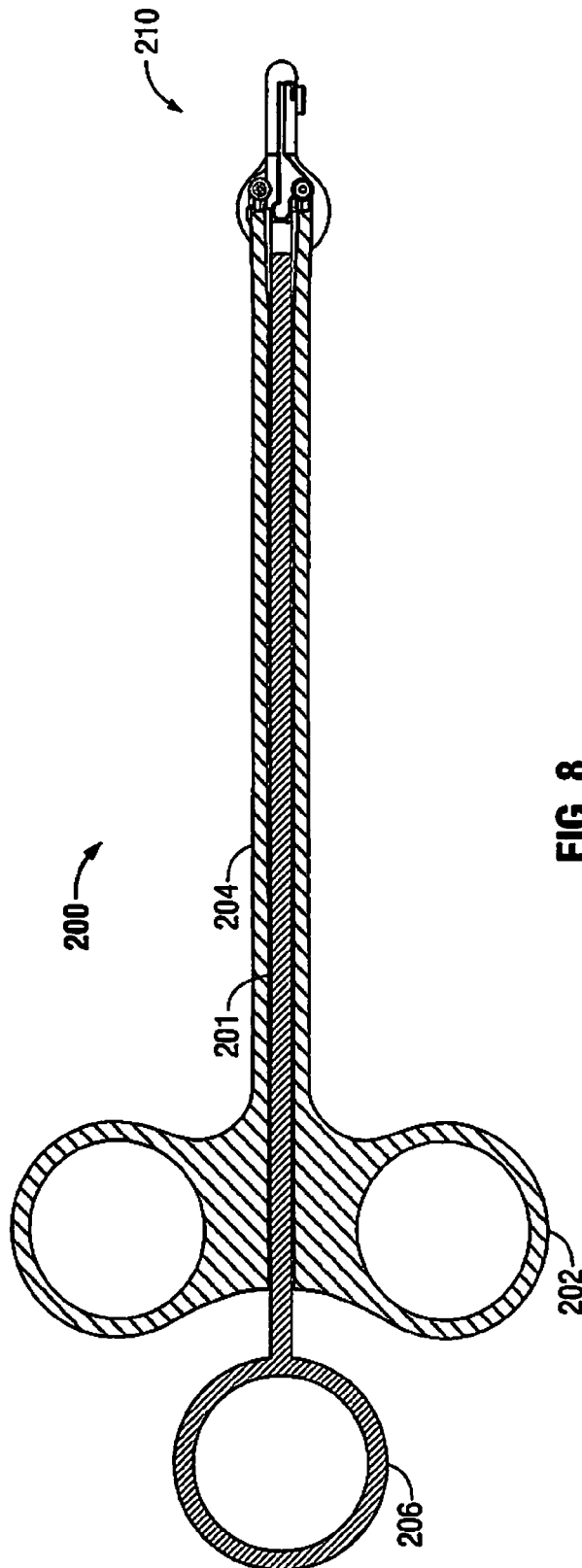


FIG. 8

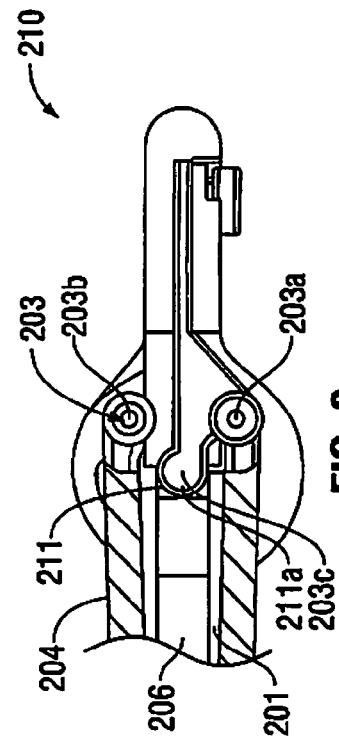


FIG. 9

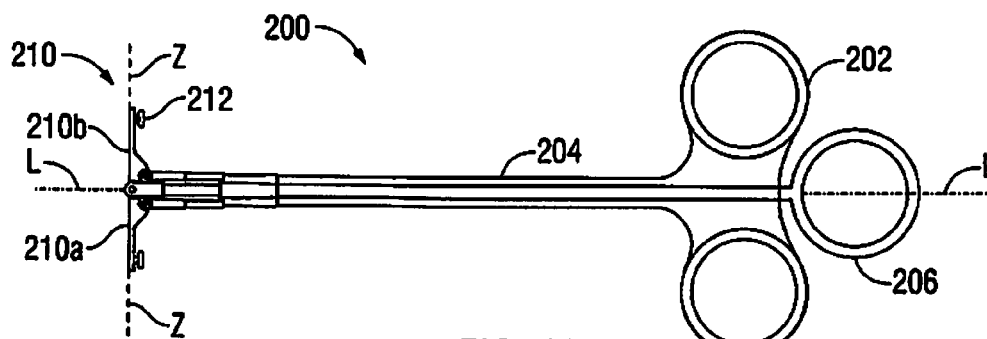


FIG. 10

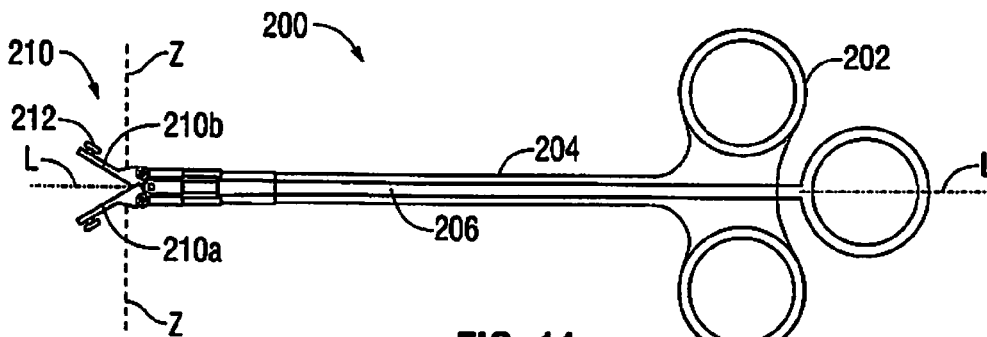


FIG. 11

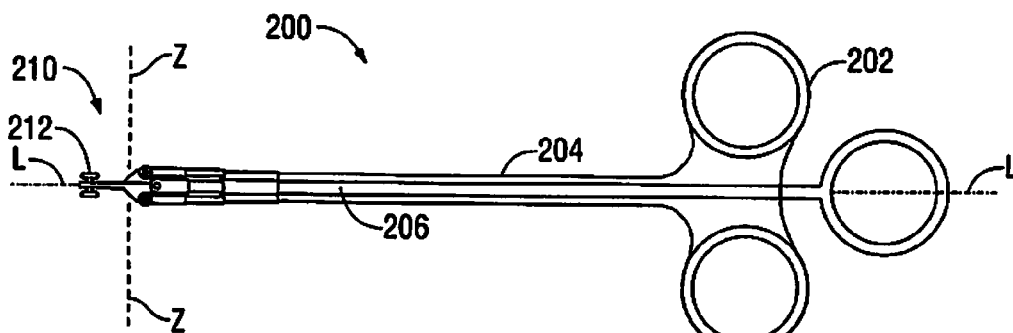


FIG. 12

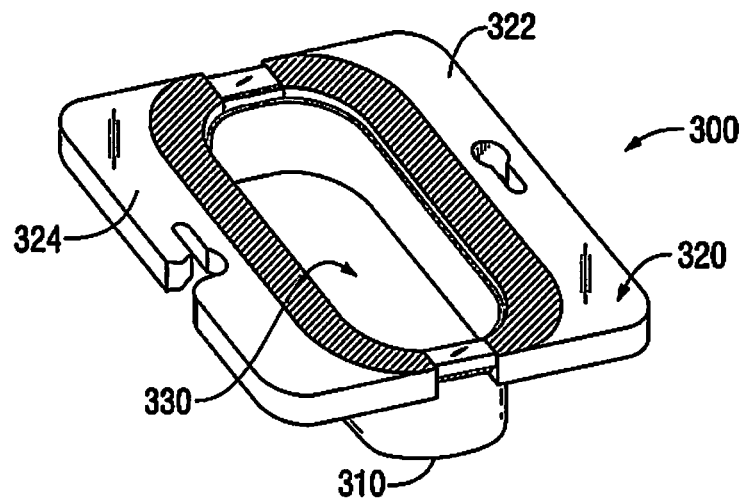
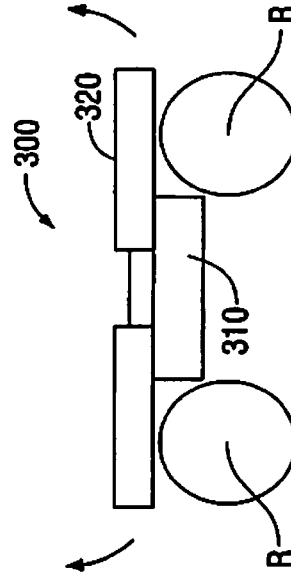
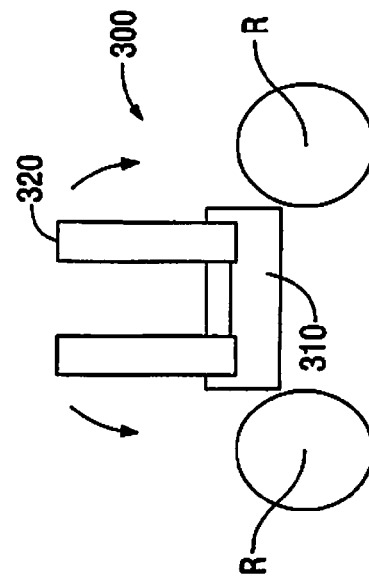
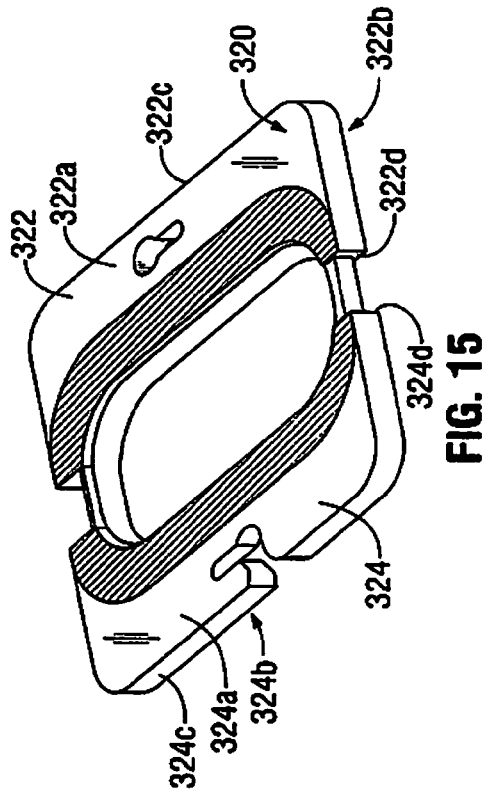
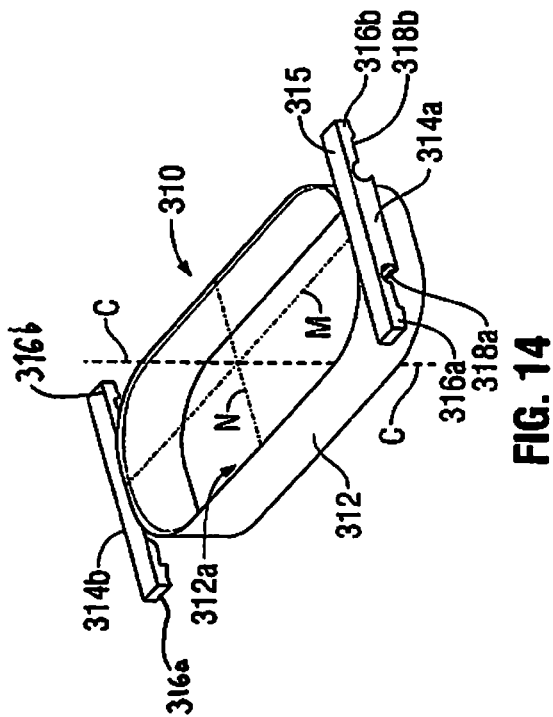


FIG. 13



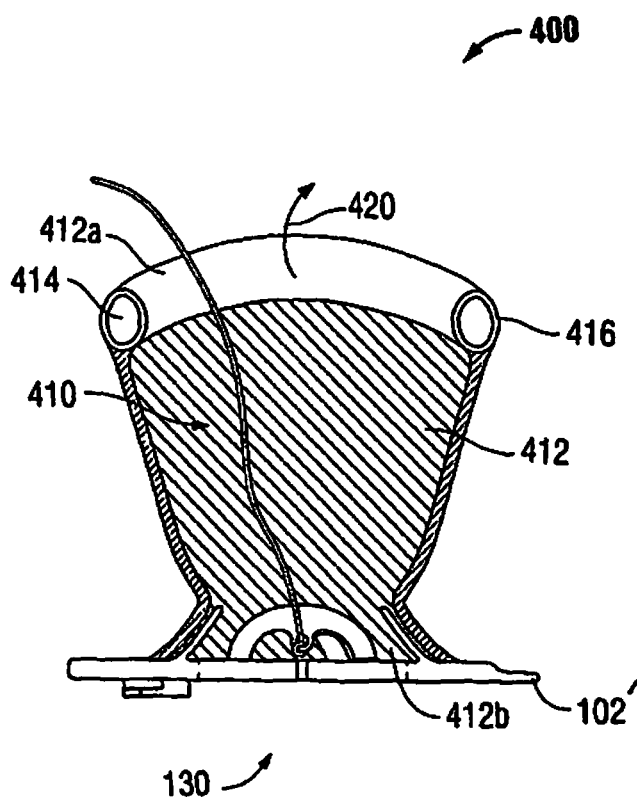


FIG. 18

THORACIC ACCESS PORT INCLUDING FOLDABLE ANCHOR

This application claims priority from provisional application Ser. No. 61/454,684, filed Mar. 21, 2011, the entire contents of which are incorporated herein by reference.

BACKGROUND

1. Technical Field

The present disclosure relates generally to devices and techniques for performing surgical procedures. More particularly, the present disclosure relates to an access device for minimally invasive surgery.

2. Background of the Related Art

In an effort to reduce trauma and recovery time, many surgical procedures are performed through small openings in the skin, such as an incision or a natural body orifice. For example, these procedures include laparoscopic procedures, which are generally performed within the confines of a patient's abdomen, and thoracic procedures, which are generally performed within a patient's chest cavity.

Specific surgical instruments have been developed for use during such minimally invasive surgical procedures. These surgical instruments typically include an elongated shaft with operative structure positioned at a distal end thereof, such as graspers, clip appliers, specimen retrieval bags, etc.

During minimally invasive procedures, the clinician creates an opening in the patient's body wall, oftentimes by using an obturator or trocar, and thereafter positions an access assembly within the opening. The access assembly includes a passageway extending therethrough to receive one or more of the above-mentioned surgical instruments for positioning within the internal work site, e.g. the body cavity.

During minimally invasive thoracic procedures, an access assembly is generally inserted into a space located between the patient's adjacent ribs that is known as the intercostal space, and then surgical instruments can be inserted into the internal work site through the passageway in the access assembly.

In the interests of facilitating visualization, the introduction of certain surgical instruments, and/or the removal of tissue specimens during minimally invasive thoracic procedures, it may be desirable to spread the tissue adjacent the ribs defining the intercostal space and/or the ribs. Additionally, during these procedures, firm, reliable placement of the access assembly is desirable to allow the access assembly to withstand forces that are applied during manipulation of the instrument(s) inserted therethrough. However, reducing patient trauma during the procedure, discomfort during recovery, and the overall recovery time remain issues of importance. Thus, there exists a need for thoracic access ports which minimize post operative patient pain while enabling atraumatic retraction of tissue and which do not restrict access to the body cavity. There also exists a need to facilitate insertion of such thoracic ports into the body cavity.

SUMMARY

According to one aspect of the present disclosure, a surgical access device is provided which includes a body that includes a first member and a second member. Each member includes a top surface, a bottom surface, a leading end, and a trailing end. The first and second members are relatively movable between open and closed configurations and are positionable within an opening in tissue to provide access to an interior space of a patient. The first and second members in

the open configuration define a passage therethrough. The passage is dimensioned to permit access to the interior space of the patient for passage of a surgical instrument therethrough.

Preferably, the trailing ends are positioned in close cooperative alignment when the first and second members are in the open configuration and the top surfaces are positioned in close cooperative alignment when the first and second members are in the closed configuration.

In some embodiments, in the open configuration, the leading ends of the first and second members are diametrically opposed and the top and bottom surfaces of the first member are substantially aligned with the top and bottom surfaces of the second member along an axis substantially transverse to a central axis defined through the passage. In some embodiments, in the closed configuration, the leading and trailing ends of the first member are substantially aligned with the leading and trailing ends of the second member and the bottom surfaces of the first and second members are disposed in substantially mirrored relation.

In some embodiments, one or both of the first and second members include one or more flaps extending into the passage.

In some embodiments, one or both of the first and second members define one or more apertures dimensioned to facilitate the positioning of the first and the second members into the open configuration. The apertures can include a first portion and a second portion wherein the first portion is smaller than the second portion. Each of the first and second members can include a surface feature defined along the top surface thereof wherein each respective surface feature can be in contact with the other surface feature when the first and second members are in the closed configuration. One or more of the surface features may include a tapered portion.

In some embodiments, a first arm extends from one of the first and second members and a second arm extends from the other of the first and second members. In such embodiments, the first arm can define a channel dimensioned to receive the second arm such that the first arm and the second arm are engaged in close geometric fit when the first and second members are positioned in the open configuration so that the first and second members are secured in the open configuration.

In some embodiments, one or more cords may be secured to one or both of the first arm and the second arm wherein when the first and second members are secured in the open configuration, the one or more cords are actuable upon the application of a predetermined amount of force to disengage the first and second arms from a close geometric fit so that the first and second members are no longer secured in the open configuration. An opening may be defined within the first arm and/or the second arm through which the one or more cords may be secured.

According to another aspect, a surgical access system is provided and includes a surgical access device and an insertion device. The surgical access device includes a body that includes a first member and a second member. Each member is movable between open and closed configurations and is positionable within an opening in tissue to provide access to an internal space of a patient. The first and second members in the open configuration define a passage therethrough. The passage is dimensioned to permit access to the internal space of a patient for passage of a surgical instrument therethrough.

The insertion device includes a housing having a shaft extending from the housing. At least one movable element extends from a distal end of the shaft. An actuator is operably coupled to at least one movable element and is operable to

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move at least one movable element between first and second positions. The at least one movable element is releasably engageable with at least one of the first and second members of the surgical access device such that movement of at least one movable element between the first and second positions repositions the first and second members of the surgical access device between open and closed configurations when at least one movable element is engaged with at least one of the first and second members of the surgical access device.

In some embodiments, the at least one movable element is substantially aligned with a longitudinal axis of the insertion device in the first position and substantially aligned with an axis transverse to the longitudinal axis of the insertion device in the second position.

The passage defined through the first and second members in the open configuration may in some embodiments be substantially elliptical and define a plane including major and minor axes. In some embodiments, when the one or more movable elements are positioned in the second position, the one or more movable elements are prevented from crossing the plane defined by a substantially elliptical passage of the surgical access device when the one or more movable elements are not substantially aligned with the major axis defined by the substantially elliptical passage of the surgical access device.

In some embodiments, each member includes a top surface, a bottom surface, a leading end, and a trailing end, wherein the top surfaces are positioned in close cooperative alignment when the first and second members are in the closed configuration and the trailing ends are positioned in close cooperative alignment when the first and second members are in the open configuration and in the closed configuration.

In some embodiments, the first member and/or the second member of the surgical access device define one or more apertures and the one or more movable elements of the insertion device include one or more protuberances extending therefrom wherein the one or more apertures and the one or more protuberances are releasably engageable with each other. The one or more apertures can have a first portion and a second portion wherein the first portion is smaller than the second portion such that the one or more protuberances of the one or more movable elements are dimensioned to engage the smaller portion of the one or more apertures in a tight geometric fit and the larger portion in a loose geometric fit such that the one or more protuberances remain substantially secured to the smaller portion of the one or more apertures when engaged therewith and are substantially freely movable relative to the larger portion of the one or more apertures when engaged therewith.

According to yet another aspect, the present disclosure is directed to a method of accessing an internal surgical work site relative to an intercostal space defined between a patient's ribs. The method includes the step of providing a surgical access device including a body having a first member and a second member, each member including a top surface, a bottom surface, a leading end, and a trailing end. The method includes providing an insertion device including a housing having a shaft extending from the housing, at least one movable element extending from a distal end of the shaft, and an actuator operably coupled to the at least one movable element and operable to move the at least one movable element between first and second positions. The method includes the steps of coupling the at least one movable element to one or both of the first and second members, selectively positioning the first and second members between a closed configuration, where the top surfaces of first and second members are posi-

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tioned in close cooperative alignment, and an open configuration. The method further includes positioning the first and second members relative to the intercostal space with the insertion device and uncoupling the at least one movable element from at least one of the first and second members.

The method may include the step of removing the surgical access device from the intercostal space by pulling one or more cords operably coupled to the surgical access device. The method may include the step of rotating the insertion device after uncoupling the one or more movable elements of the insertion device from the first and second members of the surgical access device in order to permit removal of the insertion device through a passage defined through the first and second members of the surgical access device.

BRIEF DESCRIPTION OF THE DRAWINGS

Various exemplary embodiments of the present disclosure are described herein below with reference to the drawings, wherein:

FIG. 1 is a perspective view of the inner member of a surgical access assembly in accordance with the present disclosure shown in a closed configuration mounted to an insertion device with the membrane removed for clarity;

FIG. 2 is a perspective view of the inner member of the surgical access assembly of FIG. 1 shown in an open configuration on the insertion device with the membrane removed for clarity;

FIG. 3 is a front view illustrating a patient's skeletal structure with one embodiment of the presently disclosed surgical access device of the presently disclosed surgical access assembly of FIGS. 1 and 2 positioned within the intercostal space defined between adjacent ribs;

FIG. 4 is an enlarged, perspective view of the surgical access device of FIG. 1 shown in the open configuration;

FIG. 5 is an enlarged, perspective view of the distal end of the surgical access assembly of FIGS. 1 and 2;

FIG. 6 is an enlarged, perspective view of the distal end of the surgical access assembly of FIGS. 1 and 2 shown in the closed configuration;

FIG. 7 is an enlarged, partial perspective view of the surgical access device of FIG. 4 shown disposed between open and closed configurations;

FIG. 8 is a side, cross-sectional view of the insertion device of the surgical access assembly of FIGS. 1 and 2, the insertion device shown in the closed configuration;

FIG. 9 is an enlarged, side, cross-sectional view of the distal end of the insertion device of the surgical access assembly of FIGS. 1 and 2, the distal end of the insertion device shown in the closed configuration;

FIGS. 10-12 are progressive views of the insertion device of the presently disclosed surgical access assemblies showing the insertion device being repositioned between open and closed configurations;

FIG. 13 is a perspective view of another embodiment of the surgical access device in accordance with the present disclosure;

FIG. 14 is a perspective view of the base of the surgical access device of FIG. 13;

FIG. 15 is a perspective view of the body of the surgical access device of FIG. 13;

FIG. 16 is a front illustrative view of the surgical access device of FIG. 13 shown in the closed configuration;

FIG. 17 is front illustrative view of the surgical access device of FIG. 13 shown in the open configuration; and

FIG. 18 is a front, perspective view, in partial cross-section of another embodiment of the surgical access device in accordance with the present disclosure.

DETAILED DESCRIPTION OF THE EMBODIMENTS

Various embodiments of the presently disclosed access assembly, and methods of using the same, will now be described in detail with reference to the drawings wherein like references numerals identify similar or identical elements. In the drawings, and in the following description, the term “proximal” should be understood as referring to the end of the access assembly, or component thereof, that is closer to the clinician during proper use, while the term “distal” should be understood as referring to the end that is farther from the clinician, as is traditional and conventional in the art. Additionally, use of the term “tissue” herein below should be understood to encompass both the patient’s ribs, and any surrounding tissues. It should also be understood that the term “minimally invasive procedure” is intended to include surgical procedures through small openings/incisions performed within a confined space such as the thoracic cavity or abdominal cavity.

Referring now to the drawings, FIGS. 1-12 illustrate one embodiment of the presently disclosed surgical access assembly that is generally referred to by reference numeral 10, in use for a minimally invasive thoracic surgical procedure. The various components of the surgical access assembly 10 may be formed from any suitable biocompatible material, including, but not limited to, polymeric materials. With particular reference to FIGS. 1-2, the surgical access assembly 10 includes a surgical access device 100 and an insertion device 200. The surgical access device (access port) 100 is depicted as a thoracic access device configured and dimensioned for insertion by the insertion device 200 into the intercostal space “S” (FIG. 3), thereby providing on access port for the insertion of one or more surgical instruments (not shown) there-through for manipulation within the thoracic cavity “T” (FIG. 3). The intercostal space “S” is located between a patient’s adjacent ribs “R” through an opening or incision in tissue. A membrane (not shown in FIGS. 1 and 2) as described below preferably also forms part of the access device 100.

With reference to FIGS. 4-7, the surgical access device 100 includes a body 102 that includes a first member 110 and a second member 120. The first member 110 includes a top surface 110a, a bottom surface 110b, a leading end (or outer end or edge) 110c, and a trailing end (or inner end or edge) 110d. The second member 120 includes a top surface 120a, a bottom surface 120b, a leading end (or outer end or edge) 120c, and a trailing end (or inner end or edge) 120d. The first and second members 110, 120 are each movable between open (FIGS. 4 and 5) and closed (FIG. 6) configurations and are positionable within the opening in tissue to provide access to the intercostal space “S” (FIG. 3) defined between a patient’s adjacent ribs “R” (FIG. 3). As best shown by the arrows “A” and “B” in FIGS. 4-6, one or both of the first and second members 110, 120 may rotate as the first and second members 110, 120 move between the open and closed configurations. For example, each of the first and second members 110, 120 may rotate from between about 45 degrees to about 135 degrees between the open and closed configurations. Other degrees of rotation are also contemplated. As illustrated in FIGS. 5 and 6, each of the first and second members 110, 120 are shown rotating about 90 degrees between the open and closed configurations. The first and second members 110, 120 define a passage 130 therethrough

when positioned in the open configuration. The passage 130 is dimensioned to permit access to the intercostal space “S” (FIG. 3) for passage of one or more surgical instruments into an internal work site of a thoracic cavity “T” (FIG. 3). As best shown in FIG. 4, the passage 130 may be substantially rectangular with rounded sides (or considered as substantially elliptical with two substantially parallel straight sides), and define a place including a major axis “M” and a minor axis “N.” The passageway can also be of other shapes.

In the open configuration (FIGS. 4 and 5), the leading ends 110c, 120c are in substantially spaced relation across the major axis “M” at spaced positions along minor axis “N” as they form outer ends of the device 100. The trailing ends 110d, 120d are in substantial abutting mirrored relation across the major axis “M” and at close proximal positions along minor axis “N” as the inner edges are adjacent. Also in the open configuration, the leading ends 110c, 120c and the trailing ends 110d, 120d are substantially in the same plane, e.g., substantially similarly longitudinally positioned along longitudinal axis “L.” In the closed configuration (FIG. 6), the leading ends 110c, 120c and the trailing ends 110d, 120d are in closer proximity and preferably in substantial abutting relation across the major axis “M” and in close proximal positions along minor axis “N.” In addition, the leading ends 110c, 120c are at spaced longitudinal positions relative to the trailing ends 110d, 120d along the longitudinal axis “L” in the closed configuration. Thus, as can be appreciated leading ends 110c, 120c are on the exterior sides of the access device 100 in the open configuration shown in FIG. 4 and are moved adjacent one another in the closed configuration of FIG. 6.

With continued reference to FIG. 4, the first member 110 may include one or more flaps 112 extending into the passage 130 and the second member 120 may include one or more flaps 122 extending into the passage 130. The flaps 112, 122 may be positioned relative adjacent ribs “R” (FIG. 3). Note that during the surgical procedure, surgical tools might be inserted through the access port and torque applied can result in pressure on and damage to tissues including nerves running along the ribs. The flaps 112, 122 are designed to spread point loads and thus reduce such trauma to the tissue during the procedure.

Referring again to FIGS. 4-6, in the open configuration, the leading ends 110c, 120c of the first and second members 110, 120 are diametrically opposed and the top and the bottom surfaces 110a, 110b of the first member 110 are substantially aligned with the top and bottom surfaces 120a, 120b of the second member 120 along an axis substantially transverse to a central axis “X” defined through the passage 130. As best shown in FIG. 5, the central axis “X” may be substantially aligned with a longitudinal axis “L” of the insertion device 200. The trailing ends 110d, 120d are positioned in close cooperative alignment when the first and second members 110, 120 are in the open configuration. In the closed (e.g. folded or collapsed) configuration, the leading and trailing ends 110c, 110d of the first member 110 are substantially aligned with the leading and trailing ends 120c, 120d of the second member 120 and the bottom surfaces 110b, 120b of the first and second members 110, 120 are disposed in substantially mirrored relation. The top surfaces 110a, 120a are positioned in close cooperative alignment when the first and second members 110, 120 are in the closed configuration. That is, as the device 10 is folded, the top surfaces 110a, 120a are folded toward each other to the position of FIG. 6, where the leading ends 110c, 120c are moved adjacent one another. Bottom surfaces 120, 120b then form the outer sides of the device 100.

With continued reference to FIG. 4, the first member 110 defines one or more apertures 114 and the second member 120 defines one or more apertures 124. The apertures 114, 124 are dimensioned to facilitate the positioning of the first and the second members 110, 120 into the open configuration. The aperture 114 includes a first portion 114a and a second portion 114b. Similarly, the aperture 124 includes a first portion 124a and a second portion 124b. The first portions 114a, 124a are smaller than the second portions 114b, 124b.

The first member 110 includes a surface feature 116 defined therealong. The surface feature 116 may include one or more tapered portions 116a. Similarly, the second member 120 includes a surface feature 126 defined therealong. The surface feature 126 may include one or more tapered portions 126a. The surface features 116, 126 are in contact with each other when the first and second members 110, 120 are in the closed configuration. The tapered portions 116a, 126a of the first and second members 110, 120 may have complementary mating surfaces with at least a portion of the surface feature 116, 126 of the other respective member 110, 120. In this manner, the tapered portions 116a, 126a enable the surface features 116, 126 to engage each other in close cooperative alignment.

As best shown in FIG. 7, a first arm 118 extends from the first member 110. A second arm 128 extends from the second member 120. The first arm 118 defines a channel 118a dimensioned to receive the second arm 128 such that the first arm 118 and the second arm 128 are engaged in close geometric fit when the first and second members 110, 120 are positioned in the open configuration so that the first and second members 110, 120 are secured in the open configuration. One or more cords 140 may be secured to one or both of the first arm 118 and the second arm 128. When the first and second members 110, 120 are secured in the open configuration, the one or more cords 140 are actuable, upon the application of a predetermined amount of force, to disengage the first and second arms 118, 128 from the close geometric fit so that the first and second members 110, 120 are no longer secured in the open configuration. An opening 118b may be defined within one or more of the first arm 118 and the second arm 128 through which the one or more cords 140 may be secured.

Referring now to FIGS. 8-12, the insertion device 200, which may be disposable, includes a housing 202 having a shaft 204 extending from the housing 202 and a movable assembly 210 at a distal end of shaft 204. A lumen 201 is defined through the housing 202 and the shaft 204. One or more movable elements 210a, 210b extend from a distal end of the shaft 204 and are pivotally coupled to the distal end thereof via pins 203. In particular, first and second movable elements 210a, 210b may be secured on opposed ends of the distal end of the shaft 204 via pins 203a, 203b so that they pivot in opposite directions. An actuator 206 is operably coupled to the movable elements 210a, 210b and is operable to move the movable elements 210a, 210b between first and second positions. As best illustrated in FIG. 9, the distal end of the actuator 206 may be pivotally connected via pin 203c to extensions 211 extending from each respective movable element 210a, 210b. Extension 211a of first movable element 210a enables the first movable element 210a to rotate about both pins 203a and pin 203c when the actuator 206 is longitudinally translated. Similarly, the extension (not shown but identical to extension 211a and disposed on the opposed side in substantially mirrored relation) of second movable element 210b enables the second movable element 210b to rotate about both pins 203b and pin 203c when the actuator 206 is longitudinally translated. In this respect, each of the exten-

sions 211 of the first and second movable elements 210a, 210b pivots and longitudinally translates, simultaneously, in response to the longitudinal actuation of the actuator 206. In addition, both the extensions 211 of the first and second movable elements 210a, 210b also simultaneously longitudinally translate with respect to each other; however, each movable element 210a, 210b pivots in opposed direction about pin 203c with respect to the other, as discussed above. Specifically, movable elements 210a, 210b pivot away from one another when being positioned in an open configuration and away from one another when being positioned in a closed configuration.

Referring now to FIGS. 4 and 10-12, the movable elements 210a, 210b are substantially aligned with a longitudinal axis "L" of the insertion device 200 in the first position and substantially aligned with an axis "Z" that is transverse to the longitudinal axis "L" of the insertion device 200 in the second position. The movable elements 210a, 210b of the insertion device 200 are releasably engagable with one or both of the first and second members 110, 120 of the surgical access device 100 such that movement of the movable elements 210a, 210b between the first and second positions repositions the first and second members 110, 120 of the surgical access device 100 between open and closed configurations when the movable elements 210a, 210b are engaged with one or both of the first and second members 110, 120 of the surgical access device 100. As best shown in FIG. 5, when the movable elements 210a, 210b are positioned in the second position, the movable elements 210a, 210b are prevented from crossing the plane defined by the substantially elliptical passage 130 of the surgical access device 100 when the movable elements 210a, 210b are not substantially aligned with the major axis "M" (FIG. 4) defined by the substantially elliptical passage 130 of the surgical access device 100.

With reference to FIGS. 4-5, the movable elements 210a, 210b of the insertion device 200 include one or more protuberances 212 extending therefrom. The apertures 114, 124 of the surgical access device 100 and the protuberances 212 of the insertion device 200 are engagable. The protuberances 212 are dimensioned to engage the smaller first portions 114a, 124a of the apertures 114, 124 in a tight geometric fit and the larger second portions 114b, 124b in a loose geometric fit such that the one or more protuberances 212 remain substantially secured to the first portions 114a, 124a of the apertures 114, 124 when engaged therewith and are substantially freely movable relative to the second portions 114b, 124b of the apertures 114, 124 when engaged therewith.

With reference now to FIGS. 13-17, an alternative embodiment of the presently disclosed surgical access device will be discussed. The embodiment disclosed herein below is similar to the surgical access device 100 discussed above, and accordingly, will only be discussed to the extent necessary to describe the differences in structure and operation thereof.

FIG. 13 illustrates an embodiment of the presently disclosed surgical access device that is identified by the reference numeral 300. The surgical access device 300 includes a base 310 and a body 320 operably coupleable to the base 310. As best shown in FIG. 14, the base 310 includes a support 312, a first wing 314a, and a second wing 314b. The first and second wings 314a, 314b are substantially identical and are secured to opposite ends of the support 312. The first and second wings 314a, 314b each include a planar surface 315 on which the body 320 is positioned. The support 312 defines a passage 312a that is substantially elliptical and defines a major axis "M" and a minor axis "N." The first and second wings 314a, 314b each include first and second elements 316a, 316b. The first and second elements 316a, 316b are

pivotable between a folded condition, where the first and second elements **316a**, **316b** are substantially aligned with a central axis "C" defined through the passage **312a**, and an unfolded condition, where the first and second elements **316a**, **316b** are substantially aligned with minor axis "N," which is transverse to the central axis "C." The first and second elements **316a**, **316b** each define a contoured surface **318a**, **318b**. The contoured surfaces **318a**, **318b** are dimensioned to engage complimentary mating surfaces (not shown) defined on the bottom surface of the body **320** of the surgical access device **300** such that pivoting, e.g. folding, of the first and second elements **316a**, **316b** folds the connected body **320** as described below.

Referring now to FIG. 15, the body **320** includes a first member **322** and a second member **324**. The first member **322** includes a top surface **322a**, a bottom surface **322b**, a leading end **322c**, and a trailing end **322d**. The second member **324** includes a top surface **324a**, a bottom surface **324b**, a leading end **324c**, and a trailing end **324d**. The first and second members **322**, **324** are each movable between (open) unfolded (FIG. 17) and (closed) folded (FIG. 16) configurations and are positionable within the opening in tissue to provide access to the intercostal space "T" (FIG. 3) defined between a patient's adjacent ribs "R." One or both of the first and second members **322**, **324** may rotate as the first and second members **322**, **324** move between the unfolded and folded configurations. As illustrated in FIGS. 16-17, each of the first and second members **322**, **324** are shown rotating about 90 degrees between the unfolded and folded configurations, although other degrees of rotation are also contemplated. As best shown in FIG. 13, the first and second members **322**, **324** define a passage **330** therethrough when positioned in the unfolded configuration. The passage **330** is substantially aligned with the passage **312a** when the first and second members **322**, **324** are in the unfolded configuration so that passages **312a** and **330** are dimensioned to permit access to the intercostal space "T" (FIG. 3) for passage of one or more surgical instruments into an internal work site. Each passage **312a** and **330** may be substantially rectangular with rounded ends and define a plane including a major axis "M" and a minor axis "N." Each of the passages **312a**, **330** are substantially similar to passage **130** discussed above. Other shapes of the passage are also contemplated.

The access device **300** can be composed of several components to facilitate the use of different material properties in different areas of the device **300**. Since the base **310** is designed to flex it can be made of a material such as polypropylene. Since body **320** is attached, e.g. welded or bonded, to a membrane, it is composed of a material that is compatible with the material of the membrane. It is also envisioned that various molding techniques can be utilized to manufacture device **300** to allow different materials to be used in different regions of a component.

In the open configuration (FIG. 17), the leading ends (or outer ends) **322c**, **324c** are in substantially spaced relation across the major axis "M" at spaced positions along minor axis "N" and the trailing ends (or inner ends) **322d**, **324d** are in adjacent (or in some embodiments abutting) mirrored relation across the major axis "M" and at close proximal positions along minor axis "N." Also, in the open configuration, the leading ends **322c**, **324c** and the trailing ends **322d**, **324d** are substantially in the same plane, e.g., substantially similarly longitudinally positioned along longitudinal axis "L." In the closed configuration (FIG. 16), the leading ends **322c**, **324c** and the trailing ends **322d**, **324d** are in substantial mirrored relation across the major axis "M" and in close proximal positions along minor axis "N." In addition, the leading ends

322c, **324c** are at spaced longitudinal positions relative to the trailing ends **322d**, **324d** along the longitudinal axis "L" in the closed configuration.

With reference now to FIG. 18, another alternative embodiment of the presently disclosed surgical access device will be discussed. The embodiment disclosed herein below is similar to the surgical access device **100** discussed above, and accordingly, will only be discussed to the extent necessary to describe the differences in structure and operation thereof.

FIG. 18 illustrates another embodiment of the presently disclosed surgical access device that is identified by the reference numeral **400**. Surgical access device **400** includes a membrane assembly **410** extending from body **102'**, which is identical to body **102** of FIG. 1 (except for the membrane attachment). Body **102'** can be inserted into the patient using the insertion device **200** in the same manner body **102** is inserted. The membrane assembly includes a flexible membrane **412** and a ring **414**. The flexible membrane **412** includes proximal and distal ends **412a**, **412b**. The distal end **412b** of the flexible member **412** may be coupled to and extend proximally from the internally positioned body **102** of the surgical access device **400**. The flexible membrane **412** is generally funnel shaped and protects and isolates tissue surrounding the surgical access device **400** from the passage **130** extending therethrough, thus reducing the risk of tissue damage and/or infection during the surgical procedure. The flexible membrane **412** may be configured for soft tissue retraction and may be of sufficient elasticity to permit retraction of a wide range of tissue thicknesses since there may be a wide range of tissue thicknesses among different patients. Furthermore, the flexible membrane **412** is formed of a material of sufficient strength to prevent accidental tearing and/or puncture by surgical instrumentation inserted through the surgical access device **400**. Additionally, the flexible membrane **412** may be made from a bio-compatible material to reduce the incidents of adverse reaction by a patient upon contact with the patient's tissue. Flexible membrane **412** may also be made of a transparent material to allow the surgeon to better visualize the surgical site and surrounding tissue.

The continuous ring **414** is coupled to the proximal end **412a** of flexible membrane **412** outside the patient. Ring **414** may be disposed through a loop **416** formed at the proximal end **412a** of flexible membrane **412**. Proximal end **412a** of flexible membrane **412** may be folded back onto and adhered to flexible membrane **412** to define loop **416** therebetween, or, alternatively, proximal end **412a** of flexible membrane **412** may be engaged to ring **414** via any other suitable mechanism. Ring **414** may be made from a flexible or a semi-rigid material. The ring **414** may be sufficiently rigid to retain membrane **412** in an open, tensioned configuration, while being somewhat flexible such that ring **414** may be rotated about a circumference thereof to roll, or wind-up flexible membrane **412** therearound, as shown by arrows **420**. Thus, as ring **414** is rotated in the direction of arrows **420**, membrane **412** is rolled-up around ring **414** and tensioned, thereby flexing the surgical access device **400** further outwardly to retract tissue and/or to expand the passage **130** extending through the surgical access device **400**.

With continued reference to FIGS. 1-18, use and operation of the presently disclosed surgical access assembly **10** will be discussed during the course of a minimally invasive surgical procedure. While the surgical access assembly **10** will be discussed in the context of a thoracic procedure, it should be appreciated that the following discussion of the surgical access assembly **10** is applicable to other minimally invasive surgical procedures.

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Initially, the opening is made in the outer tissue wall of the thoracic cavity "T" (FIG. 3). Thereafter, if not already having been coupled to one of the presently disclosed surgical access devices, the insertion device **200** is coupled thereto. As best shown in FIG. 5, the movable elements **210a**, **210b** of the insertion device **200** are coupled to one or both of the first and second members of one of the presently disclosed surgical access devices. In this manner, the protuberances **212** of the movable elements **210a**, **210b** are positioned within the larger second portions **114b**, **124b** of the apertures **114**, **124**. Then, the movable elements **210a**, **210b** of the insertion device **200** are rotated so that the protuberances **212** couple with the smaller first portions **114a**, **124a** in close geometric fit, whereby the protuberances **212** are substantially secured to the first portions **114a**, **124a**. As such, the insertion device **200** is enabled to reposition the surgical access device between open (FIGS. 2, 13 and 17) and closed (FIGS. 1, 6 and 16) configurations upon the actuation (e.g., longitudinal translation) of the actuator **206**. In the closed configuration, the surgical access device is in an approximated position such that the surgical access device assumes a reduced profile defining a smaller transverse dimension than in the open configuration. The reduced transverse dimension facilitates atraumatic insertion and removal of the surgical access device.

With the insertion device **200** maintaining the surgical access device in the closed configuration (FIGS. 1 and 6), the clinician, with the insertion device **200**, inserts the surgical access device into the opening and positions the surgical access device in the intercostal space between adjacent ribs "R" into desired placement for providing the clinician access to the thoracic cavity "T" (FIG. 3). Specifically, the insertion device **200**, with reference to FIGS. 10-12, is actuated via the actuator **206** in order to reposition the surgical access device into the open position so that the surgical access device may be positioned between adjacent ribs "R."

With continued reference to FIGS. 10-12, when actuation is desired, the clinician translates the actuator **206** in the distal direction. The actuator **206** longitudinally translates so that each movable element **210a**, **210b** moves from the closed configuration to the open configuration, whereby the surgical access device coupled thereto also moves from the closed configuration to the open configuration. In order to secure the surgical access device in the open configuration, the actuator **206** is translated to a distal-most position. With particular regard to surgical access device **100**, the first and second arms **118**, **128** of the first and second members **110**, **120** engage in close geometric fit in order to maintain the surgical access device **100** in the open configuration when positioned between the adjacent ribs "R."

Referring now to FIG. 18, in embodiments that include the membrane assembly **410**, the flexible membrane **412** may be positioned proximally of the opening so that it protects and isolates the surrounding tissue. In addition, the flexible membrane **412** may be tensioned, e.g., via the ring **414**, by pulling the ring **414** or rotating the membrane **412** about the ring **414**, to realize the desired positioning. In some embodiments, the ring **414** can be expandable by sliding first and second ring components away from each other to tension the membrane.

With reference again to FIG. 5, the insertion device **200** may then be uncoupled from surgical access device in order to permit removal of the insertion device **200**. In particular, the one or more movable elements **210a**, **210b** are rotated so that the protuberances **212** move into the second portions **114b**, **124b**, thereby enabling the movable elements **210a**, **210b** to be uncoupled.

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After uncoupling the movable elements **210a**, **210b** of the insertion device **200** from the surgical access device, the insertion device **200** can then be repositioned into the closed configuration upon the proximal translation of the actuator **206** (FIG. 12). In the closed configuration, the insertion device **200** assumes a reduced profile defining a smaller transverse dimension than in the open configuration. The reduced transverse dimension facilitates atraumatic insertion and removal of the insertion device **200**. Once positioned in the closed configuration, the insertion device **200** may be atraumatically removed through the passage of one of the presently disclosed surgical access devices.

After removal of the insertion device **200**, the clinician carries out the remainder of the surgical procedure by passing one or more surgical instruments through the passage of one of the presently disclosed surgical access devices. However, it should be appreciated that some instruments may be passed through the passage while the insertion device **200** is coupled to the surgical access device.

The surgical instrument(s) inserted through one of the presently disclosed surgical access devices may be any surgical instrument(s) configured and dimensioned to pass through one of the passages of the presently disclosed surgical access devices, and adapted to perform a surgical, diagnostic, or other desired procedure. For example, suitable surgical instruments may include an endoscopic apparatus, which perform a variety of functions such as the application of surgical clips or other such fasteners, the cutting of body tissue, and/or specimen retrieval for removing an internal tissue sample.

In order to facilitate passage of the surgical instrument(s) into the thoracic cavity "T," and/or removal of the surgical instrument(s) therefrom, it is envisioned that surgical instrument(s), and or the insertion device **200**, and/or any of the presently disclosed surgical access devices, may be partially, or entirely, coated with a biocompatible, lubricous material.

Following completed use of the surgical instrument(s), the instrument(s) are withdrawn from the surgical access device. The surgical access device may then be returned to the closed configuration, via reinsertion and coupling of the insertion device **200** as described above. After coupling the insertion device **200** to the surgical access device as described above, the actuator **206** is then proximally translated so that one or more movable elements **210a**, **210b** reposition the surgical access device into the closed configuration for facilitating removal of the surgical access device from between the adjacent ribs "R." In this respect, the reduced profile of the surgical access device in the closed configuration allows for atraumatic removal of the surgical access device from the intercostal space "S."

Alternatively, the surgical access device may be repositioned into the closed configuration for removal upon the application of a predetermined amount of force to the one or more cords **140** as best illustrated in FIG. 7. The one or more cords **140** impart a force upon the surgical access device that enables the surgical access device to approximate the closed configuration for facilitating removal of the surgical access device from the intercostal space "S." With particular regard to the surgical access device **100**, the predetermined force causes the first and second arms **118**, **128** to become disengaged, thereby enabling the first and second members **110**, **120** to be repositioned such that they approximate towards the closed configuration for facilitating removal of the surgical access assembly **100** from between the adjacent ribs "R." In this respect, the reduced profile of the surgical access device

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100 in the closed configuration allows for atraumatic removal of the surgical access device 100 from the intercostal space "S."

Persons skilled in the art will understand that the structures and methods specifically described herein and illustrated in the accompanying figures are non-limiting exemplary embodiments, and that the description, disclosure, and figures should be construed merely exemplary of particular embodiments. It is to be understood, therefore, that the present disclosure is not limited to the precise embodiments described, and that various other changes and modifications may be effected by one skilled in the art without departing from the scope or spirit of the disclosure. Additionally, it is envisioned that the elements and features illustrated or described in connection with one exemplary embodiment may be combined with the elements and features of another without departing from the scope of the present disclosure, and that such modifications and variations are also intended to be included within the scope of the present disclosure. Accordingly, the subject matter of the present disclosure is not to be limited by what has been particularly shown and described.

What is claimed is:

1. A surgical access device comprising a body having a first member and a second member, the first and second members being relatively movable between an open and a closed configuration and being positionable within an opening in tissue to provide access to an interior space of a patient, each of the first member and the second member includes a top surface, a bottom surface, a leading end, and a trailing end, the top surfaces being positioned in close cooperative alignment when the first and second members are in the closed configuration, the trailing ends being positioned in close cooperative alignment when the first and second members are in the open configuration, the first member including a first arm extending therefrom, the second member including a second arm extending therefrom, the first arm defining a channel therein, the channel dimensioned to receive the second arm such that the first arm and the second arm are engaged in close geometric fit when the first and second members are positioned in the open configuration so that the first and second members are secured in the open configuration, at least one cord secured to at least one of the first arm and the second arm, wherein when the first and second members are secured in the open configuration, the at least one cord is actuable upon the application of a predetermined amount of force to disengage the first and second arms from the close geometric fit so that

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the first and second members are no longer secured in the open configuration, wherein in the open configuration the first and second members define a passage therethrough, the passage being dimensioned to permit access to the interior space for passage of a surgical instrument therethrough, wherein each of the first and second members rotates about 90 degrees relative to a central axis defined through the passage as the first and second members move between the open and closed configurations.

2. The surgical access device according to claim 1, wherein at least one of the first and second members defines at least one aperture dimensioned to engage a portion of a surgical instrument to facilitate the positioning of the first and second members into the open configuration.

3. The surgical access device according to claim 2, wherein the at least one aperture includes a first portion and a second portion, wherein the first portion is smaller than the second portion.

4. The surgical access device according to claim 1, wherein the first member includes at least one flap extending toward the second member when the first and second members are in the open configuration.

5. The surgical access device according to claim 1, further comprising an opening defined within at least one of the first arm and the second arm through which the at least one cord is secured.

6. The surgical access device according to claim 1, wherein each of the first and second members includes a tapered portion defined along the top surface thereof, each respective tapered portion being in contact with the other tapered portion when the first and second members are in the closed configuration.

7. The surgical access device according to claim 1, wherein in the open configuration, the leading ends of the first and second members are diametrically opposed and the top and bottom surfaces of the first member are substantially aligned with the top and bottom surfaces of the second member along an axis transverse to the central axis defined through the passage.

8. The surgical access device according to claim 7, wherein in the closed configuration, the leading and trailing ends of the first member are substantially aligned with the leading and trailing ends of the second member and the bottom surfaces of the first and second members are disposed in substantially mirrored relation.

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